

# MEDICAL AND SURGICAL REPORTER

No. 1705.

PHILADELPHIA, NOV. 2, 1889.

VOL. LXI.—No. 18.

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## CLINICAL LECTURES.

### CHOREA.—PARALYSIS OF ANTE- RIOR TIBIAL NERVE.

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### Chorea.

*Gentlemen:* The first patient I present to  
you this afternoon is 19 years of age, and  
from the mother we gather the following:  
His father is living, but has been suffering  
from rheumatism for fifteen years, being first  
attacked when 35 years of age. His state  
of health before that was good. This young  
man was attacked with rheumatism in the  
joints two years ago, and was compelled to  
stay in bed for three months. He then got  
up, went to work and worked four months,  
when the disease returned. The second

attack was so severe that it was hard work  
for him to get about, being able to walk a  
little, but not much. It took him more than  
three months to get over the second attack,  
and he has not been well since that time.  
Now, this boy is the son of a father who has  
been suffering with rheumatism more or less  
for the last fifteen years. Two years ago he  
was attacked with rheumatism in the joints,  
which was followed by swelling of the joints,  
tenderness, and more or less debility, last-  
ing for a number of months. He seems to  
have recovered from the first attack and was  
about for a time, when a second attack  
occurred from which we are told he only  
partially recovered at the end of three  
months. Ever since the patient has been in  
a debilitated condition, with incapacity for  
locomotion and active exertion. About four  
months ago he manifested a new series of  
symptoms. He began to move and turn  
the fingers little by little, and this gradually  
increased. About this time he had a fuss  
with his companions, after which he grew

nervous, the agitation of the fingers growing worse. The mental excitement consequent upon a little unpleasantness with some of his companions developed these nervous, jerky movements which you see. Four months ago he could not walk very well; he felt dizzy, and in some instances would fall. You notice the involuntary jerk in his leg, arm or foot, from time to time, showing a disturbance of the nervo-muscular apparatus. His mother thinks he is growing worse. She tells us that things drop out of his hands, and that the right hand is worse than the left. We will ask him to hold a glass of water with the right hand. You notice the awkwardness with which he holds it. As he changes the glass from the right to the left hand you observe there is a jerk of the head and neck; he seems to move the whole body. We also learn that there is some difficulty in his speech; that he cannot speak as clearly and distinctly as he used to, and it is gradually growing worse. He sleeps fairly well, but towards morning wakes up, throws himself around in bed, and is more restless than he should be. In the mornings he is cross; nothing satisfies him. After the first hour he feels better. Observe also the expression of his countenance—that is worth fixing in your minds.

Can any of you from this history give me a diagnosis of this case? What shall we call this disorder? I am not surprised that you hesitate; the visible phenomena are not as distinct in this as in many cases of the disease. It is a case of *chorea*, and a very interesting one it is in many points of view. It is not interesting as a specimen of the peculiar movements of chorea,—that is true. It is a very easy thing to make a diagnosis where you have a typical case of choreic movement, but there are cases of chorea in which the movements are not so conspicuous, but in which other phenomena are more prominent, and this is one of them. In the first place, the connection between the disease and rheumatism is marked. I told you that he has been suffering with rheumatism for two years, after which symptoms of chorea manifested themselves. This shows very distinctly the relationship which we so frequently discover between chorea and ordinary rheumatism; so much so that chorea is by many writers ranked as a sequela of rheumatism. Another point is the fact that one side of the body suffers more than the other; and in this case it is

the right side. He handles any article that you give to him better with the left than with the right hand. That illustrates the tendency of the disease to be one-sided. The disorder is sometimes met with affecting one side only of the body—a hand or arm will be in a state of movement and incapacitated for use, while the corresponding member is in good condition: a hemichorea. Then, again, you notice that the jerk is one of the evidences of a tendency to irregular movement in this case. Another fact worthy of your notice is the debility and incapacity for use of the limbs on one side more than on the other, which exists here in a marked degree. This is true of certain cases of chorea; the paretic condition of the muscles is a marked feature of the disorder; so much so in young children that when you find what is called partial paralysis involving one or more of the limbs of the patient without any apparent reason for it, you should suspect the existence of chorea; what is sometimes spoken of as the paralytic form of the disease in contradistinction to the jactitatory form of the disorder where the ordinary movements are so conspicuous as to enable us to make a diagnosis at once. This resembles in that respect those cases of paralytic chorea.

I desire to call your attention to another feature of the case,—the effect that is sometimes experienced by the brain. Chorea is a disorder which manifests itself conspicuously in the muscles of locomotion and of movement. It is the fact in the majority of instances, however, that it is not the spinal cord and the muscles connected with the spinal centers alone that suffer, but the muscles of expression are affected; those muscles that are connected with the brain through the facial nerve are involved to a very great extent in many of the cases, and as a consequence of the enfeeblement of the facial nerve and of the muscles connected with it, there is a loss of the natural expression of countenance. The patient seems dejected, debilitated, or apathetic, or has even a silly expression of countenance, and if you converse with him you not infrequently discover a corresponding debility in the mental processes. He no longer exhibits that mental vigor which is characteristic of health, and sometimes there is such a grave departure from the normal standard that he is almost insane for the time being, under the influence of the cerebral weakness which comes as a part of the disease.

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Now, these tendencies are strikingly illus- trated in the case before you. The expres- sion of the patient, the history the mother gives of mental disturbance occurring dur- ing the morning hours rather than at other times of the day, are proof of this. In the morning when the patient awakens, some- what debilitated, a number of hours having passed without anything to eat, where there is defective digestion and nutrition, you will find him complaining bitterly of bad feel- ings, uneasiness, peculiar sensations; he is fretful and cross. This fretfulness and wear- isomeness and the general bad feeling con- tinue until the child has had something to eat and has digested his food sufficiently to be renewing the stream of nutrition that is required for the sustentation of the brain.

With regard now to the treatment of such a case as this. The treatment should be two-fold. It should be directed towards the symptoms of the disease itself, and also to- wards the predisposition which exists and is dependent upon defective nutrition, espe- cially with reference to the rheumatic dia- thesis. As far as the treatment of the jacti- tation is concerned, very little is necessary, as there is not much of it. The thing that is most important here is to build up the patient, increase the integrity and functional capacity of his brain and spinal cord gen- erally. That can best be accomplished by the administration of arsenic and tonics, cod-liver oil, a nutritious diet, milk, cream, and butter in abundance. All these things must be administered for a long period of time. Where the patient fails to respond in three months to that course of treatment, or does not improve, it is well to add strychnia to the treatment. Chronic cases after having been treated in the manner indicated will begin to improve much more rapidly if you add small doses of strychnia to the medicine. In a case like this it would be well to commence with the fortieth of a grain of strychnia, three times a day, and increase it to the twentieth of a grain if necessary. You do this for its tonic effect. Instead of increasing the jactitation in the chronic cases, it gives more steadiness to the mus- cles. Chorea is a disease of debility, and anything that increases the vigor will steady the nerves of the patient, and this is what you do when you administer a drug like strychnia. It increases the vigor of the spinal cord and brain. In addition, the patient should be given quinine, iron, etc. He should go out in the open air a good

deal, and should be warmly clad. Gener- ally in those cases, where there is a tendency to the establishment of chronic rheumatism, or relapse, the treatment I have indicated is the treatment that may possibly prevent these relapses.

You will find in the treatment of chronic rheumatism that cod-liver oil is one of the most useful remedies that can be given to obviate the tendency to recurrence of the rheumatic paroxysms.

The question arises in this case, whether the heart is diseased. I find after examina- tion no evidence of disease of the heart; though it is a common thing in chorea to meet with valvular disease of the heart. Little varicose nodules form upon the mar- gins of the valves of the heart, these are sometimes detached, and emboli are washed by the current of blood into the smaller ar- teries of the brain and serve to produce thrombosis there. The interruptions of the circulation in the brain sometimes occur to such an extent that some writers have thought this to be the cause of chorea. But there are many cases in which the cerebral dis- turbance is not so marked as in this case, and in which there is no disease of the heart. The heart here is not affected, con- sequently there can be no plugging of ves- sels in the brain from embolic fragments derived from the valves of the heart. The disease is part of a disease of the general system and is consequent upon the direct effect of the poisonous blood upon the brain and of the nerve centers generally.

#### Acute Chorea.

The second patient I show you presents the features of a case of acute chorea. It is impossible for the patient to keep his hands still. His shoulders shrug, his fingers twitch, and his mouth is more or less dis- torted from time to time, showing plainly the involuntary movements of the muscles. The patient, a boy 10 years of age, has been troubled this way for about three weeks. Children between the ages of seven and twelve are the children most frequently brought to our clinic with this disorder. He was attacked about the time that the public schools commenced, and had had no sickness previous to that. We have no his- tory of lameness, stiffness, or of rheumatism. There are no evidences of cardiac disease beyond a rapid, violent beat of the heart.

As a general thing acute chorea lasts for two months or more. The general average



of a large number of cases collected by different observers is something over sixty days. Between sixty and seventy days is the usual duration for cases of chorea. Some of them recover in much less time than that; while other cases of the disease continue for a longer period of time, and occasionally we meet with cases that remain permanent. But the vast majority get well after such a uniform period that we feel disposed oftentimes to look upon the disease as self-limited.

So varied are the modes of treatment in vogue—with about the same result—that we are tempted to believe sometimes that treatment has but little effect upon the duration of the disease. I do not know but that this is a fact. Nevertheless you should not on that account neglect treatment; for it is very necessary, and the reason lies in the predisposition of the patient. In the other patient there was a predisposition to rheumatism. In a very large proportion of cases there is some hereditary defect; the children are members of families in which consumption, rheumatism, or some of the evidences of constitutional weakness or predisposition to the disease are met with. Now and then this condition of the bodily tissues and organs demands your careful attention as physicians. You should therefore pay particular attention to the building up of the system by giving tonics and restoratives that will make the child permanently stronger; in that way you will do the patient a great deal of good.

I should advise that the child before us be given Fowler's solution in full doses, and along with it iron and quinine, and a good diet. The child seems to be tolerably well nourished; so it will not be necessary to resort to oils, but certainly the mineral and vegetable tonics should be given.

With regard to the dose that may be given: large doses are the rule. Four drops of Fowler's solution are an ordinary dose of the drug. You may begin with four drops of the drug with a child of this age. They tolerate the remedy very well indeed; then you may increase it to 15, 20, 25, or even 30 drops. You should examine the patient every day or two in order to ascertain whether any symptoms of poisoning are apparent. If you see redness or puffiness of the lids and other symptoms of irritation manifesting themselves, you should cease to advance with the drug. But it is remarkable how tolerant these patients are of this

medicine. You may give the drug in this way for a number of weeks with advantage. Do not be alarmed at a discoloration of the skin which sometimes takes place in cases of this kind. I hope we shall have an opportunity of showing you the effect of that during the winter—a peculiar discoloration of the skin that follows the use of Fowler's solution. It is transitory, and it does no harm, and the benefit to the nutrition of the patient is so correspondingly marked as to justify such large doses.

### Paralysis of the Anterior Tibial Nerve.

This patient, two weeks before the development of the disorder which we find, had rheumatism involving some territory in the right side of his body, but not apparently implicating the head or thighs as near as we can learn. It then shifted itself so that he could not place one leg up over the other. He could not extend the foot, and that parietic condition of the muscles of the leg has remained ever since. Standing in front of him we notice the muscles of the left leg are not as large as those in the right. There is not much difference in the firmness of the muscles on either side. Extension of the toes is imperfectly performed. The extensor muscles of the toes are partially paralyzed. When he walks, the toes drag, because he cannot extend them in such a way as to catch them up, consequently he has to move the whole thigh in order to get the leg up high enough to prevent the foot from dragging and the toe from catching. It is by no means a paralysis of the whole side, so far as the movement of the hip and knee-joints is concerned; it is that form consequent upon inability to raise the toes sufficient to give freedom to locomotion.

The paralysis is one which involves those muscles upon the anterior aspect of the leg and foot. Now the question is: What has caused that paralysis? It is not a paralysis involving the whole trunk of the nerves. The nerves involved are derived from the sciatic nerve trunk, but the branches of the sciatic nerve that are distributed to the muscles above the knee are all perfect in their function; there is no failure of muscular contraction above the knee, so that it is not a paralysis of the whole trunk that has taken place. It is, therefore, a case of peripheral disease of an inflammatory character, involving the anterior tibial nerve. It is not



the result of injury, or of any local disorder, as we have no history of either. And on feeling the parts we do not discover any evidence of present tenderness in the muscles, or in the sciatic nerve trunk. It is a peripheral disorder of this particular branch.

When you have a peripheral disorder of this kind, that cannot be referred directly to injury, you must look for some constitutional cause. In the majority of cases the constitutional causes that operate to produce such inflammation (when you exclude traumatism) are rheumatism and alcohol. You may have it as a consequence of the action of other poisons in the system. A local inflammation or paralysis may occur as a consequence of diphtheria, measles, typhoid fever, small-pox—all these exanthematous diseases may be followed by peripheral disorders of this kind; but there is no history of the kind here. There is, however, a history of rheumatism. The patient has rheumatic pains in other parts of his body, these pains shift their locality from time to time, and the suddenness of onset also marks the rheumatic substratum of the disorder; so that we must have here a rheumatic inflammation of the branches of the nerves distributed to the muscles that extend the foot. There is one thing to be taken into consideration in connection with this also, namely, that there may be a concurrent effect produced by the habits of the patient. We learn that this man is in the habit of taking a glass of distilled spirits of some kind every day, and has been doing so for a long period. This might create a predisposition to inflammation of the peripheral nerves. Many patients who indulge in this way for a long period of time suffer a great deal of pain, and sometimes paralysis is more or less complete. This used to be spoken of as rheumatism, but we have now learned to identify such symptoms with the consequences of alcoholic indulgence and as one of the features of chronic alcoholism. In short, I am a little suspicious that in this case we have to deal with that, as well as with a rheumatic diathesis.

The treatment should consist in the withdrawal of all alcohol. In the majority of alcoholics the withdrawal of alcohol is followed by recovery in the course of a few months at the furthest. Where there is rheumatic inflammation, it is necessary to resort to the ordinary treatment for rheumatism. We must reform the habits of the patient in the matter of drink, and give him

salicylate of sodium. It would be well to give half a drachm of the salicylate of sodium, every three hours, so that he will get two and a half or three drachms in the course of a day, until symptoms of intoxication are produced with the drug; then the frequency of the dose can be diminished, giving it three times a day. As soon as the pain is relieved you can cease the administration of salicylate; but it would be well to give him—for two weeks at least—tonic doses of iodide of potassium and guaiac, to prevent relapse.

For the relief of the paretic condition of the muscles electrical treatment should be employed. The Faradic battery is the one that you should use in such a case as this. Apply a current to the muscles of sufficient strength to produce muscular contraction, and no more. Do not cramp the muscles, but give the electricity in such a manner that you will see the muscles twitch in response to the current. When you reach that point allow the current to pass over (five minutes at a time) the affected muscles. At the end of that time stop the application. If the patient is so situated that you can get at him, you should treat him three times a day, but in ordinary Dispensary practice you cannot do it more than once a day.

533 West Adams St.

### CATARRHAL JAUNDICE.—LEAD POISONING.—TYPHOID FEVER.

DELIVERED AT THE PENNSYLVANIA HOSPITAL  
BY ARTHUR V. MEIGS, M. D.,  
VISITING PHYSICIAN TO THE PENNSYLVANIA HOSPITAL.

#### Catarrhal Jaundice.

*Gentlemen:* This patient was admitted two days ago. He is 24 years of age, single, born in Germany and has been three months in America. He is employed in a morocco factory. His family history is good. He does not use tobacco nor whiskey. He had an attack of pneumonia when ten years of age, and another at 18; he had scarlet fever at 12. His present attack began four days before admission with vomiting, diarrhoea, and chilly sensations, but without distinct chill. Two days later, he noticed that he was becoming yellow. He had no cough, but suffered with pain in the abdomen during this time. On admission his tempera-

ture was  $97^{\circ}$ , his pulse 52, his respiration 24. His tongue was pale and clean. I show you here his urine, which is rather high colored, but otherwise not unnatural in appearance. I will test it, to see if it gives the reaction for bile. I place some urine on this plate, and add a little nitric acid. I allow the acid and urine to gradually mingle, and you can now see a slight prismatic play of colors. We do not see this in normal urine.

To-day his tongue is moist and not tremulous. His conjunctivæ are quite deeply tinged with yellow. There is also some slight yellowish tinge under the tongue. His skin over the whole body shows the same greenish or deep-yellow color. Proceeding now to make a physical examination, I notice two things in connection with his heart. In the first place its action is very slow. Yesterday while resting quietly in bed his pulse was 44, and to-day it is the same; there is besides at the apex a faint, flowing systolic murmur, but as the heart sounds are clear and their rhythm natural, I judge that this is merely a so-called "anemic murmur," heard frequently in those whose blood is poor in quality. Anteriorly the percussion resonance is good and equal on the two sides. The respiratory sounds are also good, with clear vesicular expansion, which is equal on the two sides. Posteriorly, following my usual plan of percussing, I find the resonance normal in the three regions in which I percuss. We do not catch the clear sound heard in front because of the thick muscular tissues covering the back. The liver dulness in the nipple line should commence at the sixth rib and extend to the costal edge, a distance of four inches. Here, however, the dulness begins in the fourth interspace, or slightly at the fourth rib, nearly one inch too high. This cannot be due to a consolidation of the lung, as I have excluded the presence of any lung trouble. The dulness extends one and a half inches below the border of the ribs. I should say, therefore, that the liver is enlarged, though, I cannot feel it on palpation. The splenic dulness is completely marked by tympany. Yesterday, I thought there was some enlargement of the spleen, and it would be likely to be so, as in these cases with depression and slow pulse the spleen is apt to be swollen, for then the internal organs are congested, and the blood is apt to stagnate in them.

Now, what is the matter with this man?

I should say that since his admission he has had no diarrhœa; in fact, he has had but one movement of his bowels since then, and his stool was white in color. Ever since his admission, he has had a subnormal temperature. Now, his jaundice might be due to serious disease of the liver, or to some obstruction of the bile-ducts, a catarrhal condition existing there. This latter, I believe it to be, a plugging of the gall ducts by a catarrhal inflammation. The prognosis in such a case is good. In regard to treatment, we have given him the one-sixth of a grain of calomel with five grains of bicarbonate of soda every two hours, to deplete his portal circulation. We will continue this for a few days, and then give him some dilute nitro-muriatic acid to stimulate his liver, ten minims three times a day. In the course of a few days he probably will recover.

### Lead Poisoning.

The next patient I shall show you was admitted on the ninth of October. He is 52 years of age, single; born in Ireland, and has been seven years in this country. He has been constantly employed in a paint factory up to six days before his admission, when he was compelled to stop work. His family history is good. He uses whiskey and tobacco habitually. He is complaining of cramp in his belly, constipation and some giddiness. His tongue is pale and tremulous. His temperature on admission was  $97\frac{1}{4}^{\circ}$ .

Now, what have we here? The history of the case leads us to nothing, except that he is accustomed to the use of whiskey. At present he is constipated and suffering with belly-ache. He says that twice before he had a similar attack. He is rather pale; his pulse is good and natural; his arteries are somewhat atheromatous. He has worked in a paint factory for the past seven years where he was constantly handling lead. We must see if this has had any influence in the production of this trouble. In examining the gums we discover a distinct bluish line just above the teeth. The presence of this line depends largely on the patient's habits. If he is cleanly and uses his brush it is often absent. We must therefore distinguish the true line of chronic lead poisoning from that often found upon the deposits of tartar upon the teeth. This can be done by scraping the surface slightly, when if it is upon the teeth it will be removed. The blue in this case persists after scraping, and is therefore in the gum itself. There is

another point I wish to call your attention to before sending the patient away. The belly in lead poisoning is said to be scaphoid, at times is so much so as to rest upon the spinal column. As a common thing I do not find this to be the case, and you can see that this man's belly is rather full. There is also marked tympany here, which is likewise said to be absent in this condition. If the poisoning has gone far one of the characteristics is a dropping of the wrist due to a partial paralysis of the extension of the hand. Frequently this cannot be seen, but if we test the strength of the muscles we can discover some weakness. This man is considerably stronger in the flexion of his hand than in the extension.

Chronic lead poisoning shows itself usually in one of four different forms. It appears either as lead colic or colica pictonum; as asthralgia or severe pains in the joints; as some form of paralysis, of which the wrist-drop is the most common; or lastly, it may appear as the so-called encephalopathy, where the patient is suddenly seized with convulsions arising from no apparent cause. The lesions here are nil, as in a case of simple epilepsy. These forms are said to be most common in the order I have given them. Tanquerel says that the asthralgic form is the second most common, but I have never seen but one case, while I have seen many of lead colic and paralysis and one of the encephalopathy. I should say, therefore, that this order does not hold true in this country, but that paralysis was the second most common form and asthralgia quite rare.

The symptoms of chronic plumbism are varied. In the first place the patient ordinarily is pale. Then the blue line is present on the gums. The pulse is sometimes said to be slow though this is not a marked feature. There is usually constipation. We must then take into consideration the sources of entrance of the poison into the system. There are some trades more liable than others to produce lead poisoning. Thus it is often found among photographers, and lapidaries, who are accustomed to use a leaden wheel in their work. It is common among painters and workers in white lead factories. Plumbers and gasfitters frequently suffer, and weavers also from the use of a leaden shuttle. Then printers from handling type, and workers in pottery are often victims. One of the worst cases I ever saw in this hospital was in a potter who handled

the material used in glazing the vessels. File-makers and paper-hangers frequently suffer, and likewise tailors. I recall a severe case occurring in a tailor admitted to the hospital some time ago. Dr. Penrose, the resident at that time, on inquiry found that the man was in the habit of biting off his thread. On investigating the matter we learned that all of the common forms of black thread are weighted with lead, and this was the avenue through which the poison entered his system. The poisoning not uncommonly arises from the use of cosmetics, and from the drinking water which has been conveyed in leaden pipes. The water of the Schuylkill contains considerable sulphuric acid which produces a deposit of the insoluble sulphate of lead within the pipes thus rendering them innocuous. The purer the water, the greater danger there exists of lead poisoning.

The prognosis in chronic lead poisoning is bad under the conditions in which we usually find it. If we could remove the patients from the sources of poisoning we could cure our cases, but they almost always return to their trades, and in the course of time return suffering with a new attack. The prognosis, therefore, should be guarded.

In regard to the treatment there are three indications to be met. In the first place we must relieve the pain, which at times is exceedingly severe. Then, second, the extreme constipation must be treated, and thirdly we must give something to eliminate the lead from the system. We give opium for the first mentioned purpose, ten drops of laudanum every two hours, or the one-eighth of a grain of morphia two or three times a day or a hypodermic of one-sixth of a grain of morphia. We must avoid overdoing the matter so as not to produce narcosis. For the constipation, Epsom or Rochelle salts are sufficient, one-half ounce in the morning. There need be no haste in treating this condition. To eliminate the lead from the system the best remedy is the iodide of potassium. We have not given this to the man as yet. We shall give him to begin with five grains three times a day and follow later with some tonic, as iron.

### Typhoid Fever.

This man is 26 years of age, a Candian, and a student of dentistry. He has been a teacher for the past four years, and has been four weeks in Philadelphia. His family history is good. He uses neither whiskey nor



tobacco. His illness began one week before admission with fever, malaise, and diarrhoea. His tongue is dry, furred, brownish white in the center and red at the tip, and tremulous. There is no urinary disturbance. The heart, lung, and liver examination is negative. The spleen is marked by tympany. His belly, which is full, is covered with rose-colored spots which disappear on pressure. His complexion is fairly good. The diagnosis in this case is very easy. My reason for bringing the man before you was to show to you a typical exhibition of the rose-colored spots of typhoid fever. Murchison says that the number of spots is inversely proportionate to the severity of the case, but our observations are exactly opposite to his. I do not remember to have seen full eruption in a mild case. This man had a temperature of  $104\frac{1}{2}^{\circ}$  on admission, and it has never fallen below  $101\frac{1}{2}^{\circ}$ , a quite high fever. He has no bronchitis, and is doing well.

In the case which I next bring before you, and which was admitted on the twenty-ninth of July, the diagnosis was very hard to make. The patient is a mulatto, and has had typhoid fever. In a negro the rose-colored spots are always absent, and his complexion is never the typical one of typhoid fever. I thought for a time he had some form of tuberculosis, especially as his lungs were seriously involved. He is now recovering, however, and is gaining flesh and strength. I bring him before you to show the long duration of his fever. You see the period of subnormal temperature he has passed through, and I would call your attention to the fact that a patient is by no means convalescent until the temperature after being subnormal rises again to the natural point and continues normal for at least several days.

SENSE OF TASTE IN CRIMINALS.—Dr. S. Ottolenghi, a pupil of Professor Lombroso, has studied the sense of taste in criminals compared with that of other individuals. He says that in criminals the sense of taste is manifestly weak relatively to that of ordinary individuals; there is, again, a difference less marked between occasional delinquents and those who are habitual or born delinquents. Female criminals have the sense of taste still more obtuse than men of the same category. The author concludes from these remarks that this diminution in the sense of taste in criminals depends on a defect in the cerebral cortex.

## COMMUNICATIONS.

### THERAPEUTICS, AND FALSE THEORIES.

INTRODUCTORY LECTURE AT THE UNIVERSITY OF PENNSYLVANIA, OCTOBER, 1889,

BY H. C. WOOD, M. D.,  
PROFESSOR OF THERAPEUTICS.

REPORTED BY J. HOWE ADAMS, M. D.

*Gentlemen:* As we meet here for the first time I would put to you this question: "Why do you come here?" As intelligent men and students, you reply, "Because we wish to study medicine." But I persist, "Why do you wish to study medicine?" Again you reply, "Because we want to cure disease and relieve suffering." Ah! you have struck the keynote of the profession; without this apology for his existence, the physician has no right to be. Unless he can accomplish this result, he has no mission, no business in the busy world. Without therapeutics the physician is powerless to fulfill this purpose; hence to you as students this branch is all-important; it is imperative that you conquer its intricacies to reach that high position in the profession which you are all determined to hold.

Hence I feel that a little time spent in showing you how to study therapeutics will not be wasted, for it makes all the difference in the world as to the way in which we approach this branch, whether it is a pleasant, instructive task or a drudgery which becomes so irksome as to be almost imperatively shirked.

Firstly, sheer hard work is necessary at the outset; for you must learn many things which are arbitrary, which cannot be reasoned out. Learn first the classes of drugs and the meaning of their titles; then learn the individual drugs by heart. If necessary, write them on your wall and study them as you pace up and down your room. Then do not attempt to master the physiological action by rote; instead, study the symptoms of every remedy, especially when given in poisonous doses. You cannot reason these phenomena out; there is no necessity in our minds why opium in large doses should benumb mind and body; it is simply a fact, and only hard application is going to impress it on your memory. When you are perfectly familiar with the symptoms of a drug, then you must inquire, how does this

remedy act to produce these results; experiments or experience have shown that there are a certain number of ways to effect this; now, which is it? You eliminate those ways which therapeutists have shown require different conditions to act, and by direct and indirect reasoning you reach certain conclusions. These conclusions form the physiological action of the particular drug under consideration.

This was not the way in which the science has always been pursued; it is a development of the century in which we live. How was it when the first man was sick? Undoubtedly he was attended professionally by the first woman and was given more or less relief. How did the old lady, for she was most likely old by this time, reason: Adam was sick, he had certain symptoms, I gave him an herb or root dug from the ground, or possibly some excreta from an animal; he got well, hence when Adam has that disease or those symptoms again, that drug or root or excreta will cure him. And the old lady jotted this fact down in her memory. Seeing the disease, giving the remedy, and getting the relief, was the natural outcome of such experience.

On these principles, therapeutics began to grow and develop into a so-called science. The motto of the therapeutics of that day was, if you will pardon my quoting Latin, "*Post hoc propter hoc*." This idea is all wrong; it is most uncertain and fallacious. Adam may have recovered despite the remedy, or it may have done neither harm nor good, simply allowing nature to take its course. But this system of therapeutics was in vogue until 300 years ago. But the human mind is never satisfied with facts; it craves laws and broad, governing statements. In the search for leading principles, arose among other empiricisms, the "Doctrine of Signatures" which based the remedies for an organ on the resemblance which they bore to each other; for example, aloes in color, and faintly in outline, resembles the human liver; therefore aloes is of use in the diseases of the liver. It so happens that accidentally aloes by purging did good in liver-troubles. Therefore the disciples of this doctrine declared the principle to contain the true secret of therapeutics; and so for a time this theory prevailed in the medical world; simply because an accidental fact was confused with a consequential fact.

It will be necessary for me to waste a few words and a little time—for I consider it

wasted—on the only one false doctrine which has come down to the present day. Hahnemann gave to the world three great laws on which he based all medical treatment:

1. Chronic disease is due to a certain humor in the blood, which finds its truest expression in the very prevalent disease called scabies or "itch." The invention of the microscope put to flight forever this part of his theory, by showing the small animal which is the cause of trouble in this complaint.

2. The dying doctrine of the infinitesimal dose. This idea is generally misunderstood by the laity; it is not that certain substances act in minute doses on the human system; for I could take drugs of which I need place only the smallest fragment on the tip of a knife-blade and yet they would kill. The doctrine is that substances which are inert in large quantities are all-powerful when triturated and divided into the one-thousandth or ten-thousandth part of an ordinarily small dose. For example, take chalk, which in large doses has no effect on the human organism; divide it and subdivide it until the chemist can find no trace of it and the spectrum reveals no evidence of its presence; then the true disciple of Hahnemann says chalk is all potent to cure and arrest disease. In fact it may become so powerful by subdivision that it may kill, instead of curing. Shaking the drug too much may release the latent strength to such a degree that again it may be capable of disastrous results; which may be a solace and explanation to many a homœopathic practitioner.

I remember a student I had many years ago, who complained that his family were homœopaths and were constantly tormenting him to study in that school. I said, "Why didn't you then?" "Well," he replied, "I was going to, when one day I was talking to our family physician, who was of course a homœopath, and he pulled out of his pocket a small vial and holding it up, said: 'When I began to practice medicine I put in that bottle one-quarter of a grain of mercury and filled it up with sugar of milk; as fast as the vial became empty I refilled it with sugar of milk until now it is fairly alive with the spirit of healing.' That disgusted me with homœopathy, and I came here."

3. "*Similia similibus curantur*." This means, that when a disease offers certain symptoms, that remedy is indicated in small

doses, which in large doses would produce a similar condition. This was not new doctrine with Hahnemann; it is as old as Hippocrates, and in its survival shows it possesses some elements of truth. But the "Father of Lies" rolls as a sweetest morsel under his tongue that falsehood, gilded with just enough truth to pass for real gold to the public.

A law of nature allows of no exceptions; if gravity draws objects to the earth at one point and repels them at another, then we can claim that the so-called law of gravitation is false and no law at all. So with this third principle of Hahnemann. If there are exceptions, it becomes no law, but merely a number of coincidences. Let us take an example, ipecac, for instance. This drug in large doses is a powerful emetic, in small doses it serves under certain conditions to quiet the stomach. The disciples of this dogma then declare "Great is homeopathy and Hahnemann is its prophet!" But let us take up the converse of this proposition "*Dissimilia dissimilibus curantur*" and use the drug opium. Now it is well known that opium in large doses deadens and subdues the stomach; given in small doses it quiets and controls in the same way the vomiting stomach; hence the disciples of this theory claim its application to everything in medicine. These are but samples taken hurriedly from the great mass of facts gathered on the subject.

In the first place symptoms are but the surface planes of disease, which mark but imperfectly the deep currents which run beneath. Let us take again the same drug, ipecac, and give it to an irritated stomach which is vomiting because of the myriad of impulses thrown out from it. Ipecac makes the symptoms worse. In the former case, the drug restored a lost tone to the organ, while in the latter case it was but fuel added to the fire. There is no law here. As I have said, it is simply a set of coincidences.

One word as to what you shall call yourselves. According to the world medicine is divided into "old school" or allopaths, homeopaths, eclectics, down to the rabble of faith-cures and Christian Science. There is no such division, and cursed be the physician who acknowledges "schools." There are but two bodies in the field of medicine—physicians and the "paths." Try to make the public understand this; if you must have some name, let it be that of a "common-sense doctor," who, brought face to face

with the problem of life and death, is willing to save life in any way; who acknowledges no boundaries, no sects, no school; but who searches heaven and earth to find means to relieve suffering and cure disease.

Why homeopathy has so many followers, I have shown in an address before Yale College last spring. You will be supplied with copies possibly during the winter. Undoubtedly Hahnemann was a great benefactor to the medical profession not because of his theories, but for the accidental results which followed their application. The profession learned that disease was not always to be fought. Up to this time it had been treated like the seven devils of the Scriptures. It was to be cast out at any cost. The patient was bled, blistered, and purged until it grew too hot for the demon of disease to stay in the tortured body. By the action of this German theorist, who left the course of the disease practically unaffected, it was learned that a large proportion of acute sickness tends to recovery, unaided by the action of the medicinal forces called drugs. In consequence, there arose in Vienna a school of therapeutic nihilists, who believed that we have no power over disease; that it is necessary to leave everything to Nature. This was the reaction from the excessive and irrational use of drugs of the time; it had the practical import of giving the opportunity for the study of the natural history of disease.

Two important facts were brought to the attention of the profession by this Viennese school, namely,

1. That acute disease tends to recovery;
2. That it is impossible to abort its course.

Consequently you demand, What is the use or necessity of physicians in the care of such cases, if they are unable to effect the course in any way? Let me illustrate their use in acute complaints: the captain of a fast-flying ocean steamer sees in the distance over the tranquil blue water a small cloud the size of a man's hand; the mercury is falling in the barometer; and his practiced eye tells him that a cyclone is approaching. He cannot escape that storm; he cannot stay its course, but he makes taut the ship, reefs the sails, and stands ready for the blow. So with the physician; his mission is to guide his patient's course through the dangers of his sickness. He studies the ways in which the disease approaches, the methods by which it kills, and the injuries which it is apt to leave. Typhoid fever kills by



exhaustion, by high fever, by diarrhœa, by lack of digestive power due to extensive ulceration; hence here are the danger-notes for the physician. At once he puts the typhoid patient to bed, to save that strength, the last grain of which may just be sufficient to hold together the bridge which is to carry the sick man over a yawning grave. He keeps the temperature down within safe limits; for fever burns out the vital fires most quickly in this dread trouble. He secures rest at night for the sick man, to prevent the exhausting vigils in the long hours which follow midnight. In every way the leaks are stopped which are carrying off the life-blood.

The term "indication" is a most important one in all medical discourse. I will define it for you: Indication is the pointing of Nature towards relief. The diarrhœa in typhoid fever is an indication for treatment. The term goes a great ways; for it implies use not only when it is easy to see but also when it may be most obscure. It requires sagacity to read the indications in every case.

By judgment, by common sense, we learn how to use the forces called drugs in the human economy. The doctor becomes a dynamical engineer, who is to drive the most complex forces in existence, whose interplay we call "Life," and whose perturbation is sickness. To our aid we call these outside forces which fall into the arrangement which we name "Therapeutics." Hence the physiological action of remedies is the study of what they do when brought in contact with healthy organisms.

So far as it goes, therapeutics is a science, but it is by no means perfected; let us not complain; for it is my belief that it is better to live in the age when discoveries are being made, than when the world's knowledge is cut and dried. Better to live while the fruit is ripening one by one, than when it lies rotting on the ground. It is necessary to supplement pure science by empiricism, that is, the therapeutics of experience. The difference between the old and new therapeutics is this: John is given a drug in the olden times, he gets well; the credit is given to the remedy; nowadays the action of the drug is doubted, until by repeated experiments in many similar cases its value is undisputed.

Therapeutics is imperfect, more through the deficiencies of the clinician and the pathologist than from the therapist's

faults. Take the so-called specifics; how they act is largely a problem now; but as soon as the microscopist showed us the hematozoa in the blood in intermittent fever, we showed the world how quinine acted to perfect a cure. And we stand ready to do the same when the exact nature of syphilis and rheumatism is determined, for mercury and the salicylates.

### COMPOUND COMPLICATED FRACTURE OF THE SKULL: THREE CASES.

BY G. M. HAMILTON, M. D.,

ASSISTANT SURGEON, STATE HOSPITAL FOR INJURED  
PERSONS OF THE ANTHRACITE REGIONS  
OF PENNSYLVANIA.

*Case 1.* S. S., a miner, 21 years old, was admitted June 26, with a compound, complicated fracture of the skull, caused by a heavy fall of coal in the mines. The fracture extended from above and to the right of the occipital protuberance across the median line below. There was so much compression that it was not necessary to anesthetize the patient for the operation of trephining. After the fragments were removed, there was an opening in the skull, one and one-half inches wide by two and one-half long, through which the lacerated membranes and brain could be thoroughly inspected and cleansed. The dura-mater had been detached from the bone, in the vicinity of the wound, by the force of the blow, and portions of the patient's hat, small pieces of coal and other foreign matter had been forced down between the membrane and bone. These substances were carefully removed, good drainage was provided, the wound closed, and a bichloride dressing was applied. All signs of compression disappeared in a few hours. On the third day the temperature was 100.4°; but it soon began to decline, and three days later it was normal. The patient was discharged July 31, and is now again at work in the mines.

*Case 2.* W. H., of Ashland, 16 years old, was brought to the hospital on the night of July 3, with a compound, complicated fracture of the skull, the result of the explosion of a "gas-pipe cannon." The wound in the soft structures extended transversely across the forehead, immediately above the supra-orbital ridge, from the median line to

within an inch of the right ear. The bone was fractured through the frontal sinus, both the outer and inner walls being crushed and driven in upon the membranes, which together with the brain were extensively lacerated. The trephine was applied and fragments of bone and injured brain matter were removed, the wound sutured and dressed with the usual antiseptic precautions. On the morning of the second day, the temperature was  $102^{\circ}$ . Upon examination of the wound, the drainage-tube was found to be occluded by a further separation of brain tissue, and the skin to be somewhat tense from retained wound secretions. A new drainage-tube was substituted and the temperature almost immediately began to decline, reaching normal the morning of sixth day. This patient was discharged August 24.

*Case 3.* L. B., a miner, 22 years old, admitted July 6, with compound complicated fracture of the skull, involving the temporal and adjoining portions of the parietal, sphenoid, and occipital bones on the left side. This injury was also caused by a fall of coal. The patient when admitted had very grave symptoms of compression, and to relieve this, it was necessary to remove the greater part of the temporal bone—that portion only being left which contains the carotid canal. The membranes and brain were greatly injured, but the most dangerous complication was a wound of the lateral sinus, near the point where it terminates in the internal jugular vein. The fragments of bone were wedged in in such a manner as to prevent fatal hemorrhage at the time of the accident. When they were removed, the hemorrhage became so profuse as to threaten immediate death of the patient; but it was controlled by means of a graduated aseptic compress. This compress was removed at the end of seventy-two hours, and the wound was allowed to granulate. The patient is now walking about the hospital almost well enough to be discharged. On account of the removal of the temporal bone, there is, of course, permanent paralysis of the muscles supplied by the seventh nerve and complete loss of hearing on the injured side.

These three cases represent a class of fractures treated in large numbers at this institution, and the good results obtained are mainly due, in my opinion, to the operative treatment at the time of admission; to the free use of the trephine and elevator; and,

of course, to a strict adherence to the principles of antiseptic surgery. Sometimes, it is true, the fragments can be removed by means of the elevator alone, but even in these cases, Dr. Biddle considers it good, and if there is injury to the membranes and brain, necessary treatment—where it can be done—to enlarge the opening in every direction until he has a solid margin all around, with healthy membrane attached beneath. This gives a chance for free drainage and reduces to a minimum the dangers of secretions becoming diffused between the membrane and the bone. No matter how large an opening is made, all bone that is likely to become a source of irritation must be removed, and the sooner it is done, the better will be the chances of recovery.

The cases just reported were operated upon in this manner by Dr. Biddle, assisted by Dr. C. A. Dundore and myself, and in none did there develop any symptoms of meningitis, other than of strictly local character. The comparatively high temperature of *Case 2* was not due to meningitis, but to the retained secretions, as was proven by the rapid fall after re-establishing drainage.

#### OBSERVATIONS ON THE THERAPEUTICAL EFFECT OF THE VIOLET END OF THE SPECTRUM ON VISION.<sup>1</sup>

BY G. LINDSAY JOHNSON, M. A., B. S.,  
F. R. C. S.,

LONDON, ENGLAND.

In a case of retinitis accompanied by partial retinal detachment in which I had prescribed the constant use of blue glasses, I noticed an evident increase in the visual field and a corresponding improvement in vision, it occurred to me that if this improvement in vision was caused by a blue glass, which admitted more or less of the red end of the spectrum because fitted to frames which allowed a considerable amount of daylight to reach the eye, the uninterrupted and exclusive action of the blue end of the spectrum might produce a more favorable result still. After examining and preparing a very large

<sup>1</sup> Abstract of paper read at the Ophthalmological Section of the Leeds meeting of the British Medical Association. Prepared for the MEDICAL AND SURGICAL REPORTER by the author.

number of colored glasses and solutions, I succeeded in obtaining a glass which absorbed all the spectrum except the red and a portion of the orange, as well as one which cut off all the red, orange and yellow rays to within ten degrees of the E line. This latter I termed "Spectrum blue," being the nearest approach to a theoretical blue that I could get by art, while the former I call "Spectrum red." Previous to obtaining the spectrum blue glass I devised a pair of goggles, in which the glass was replaced by a trough made by fitting two thin circular plates of glass into a ring and having their surfaces parallel and at  $3\frac{1}{2}$  millimeters apart. This trough was filled with a solution of ammonio-sulphate of copper. This form of glass had to be abandoned, however, owing to the bleaching action of light on the solution. The spectrum blue glass above mentioned, on the other hand, formed a perfect substitute.

Carefully worked pieces of this glass were fitted into spectacle frame goggles which fit so close around the orbit that no light could possibly enter which did not pass through the glass. For ventilation the sides of the cups were made of two thicknesses of finest wire gauze, enclosing one of fine crape. The patients were instructed to fit on the spectacles the instant they awoke in the morning, after bathing the eyes and before putting up the blind, and to refrain from removing them until they retired to rest at night.

During the past three years a great number of patients have been treated with the spectrum blue glasses in the above way. Of the various eye diseases so treated, detached retina, optic neuritis and neuro-retinitis afforded the most satisfactory results. In nearly every case of detached retina the field of vision was largely increased, although in only four cases out of about thirty treated was the retina actually seen to have returned to its position. In every case of neuro-retinitis due to temporary causes the vision returned rapidly after a few days, although in some cases the vision had been declining or stationary for weeks previously. I find that cases which can be benefited by the use of the glasses show improvement as a rule within three days, and if no improvement shows itself at the end of a week, none may be expected. Very few cases of relapse in detached retina have been noticed, even after the glasses have been ultimately discontinued.

## REPORTS OF CLINICS.

### BELLEVUE HOSPITAL.

MEDICAL CLINIC—PROF. A. L. LOOMIS.

October 15, 1889.

### Typhoid Fever.

The first patient shown by Dr. Loomis was a man 24 years old, in perfect health up to 8 days ago, when he was suddenly attacked with six or seven chills, fever, headache and vomiting. The day before this, he was at work and suffered from no malaise or diarrhoea or headache. The first day of his illness he acknowledges some looseness of the bowels, but he declares they have been regular since. He has been getting sicker and weaker from day to day, and finding that he was not likely to improve at home, he entered the Hospital yesterday. He was found to be quite deaf, probably from large doses of quinine. He still complains of slight headache and dimness of vision.

His temperature on admission was  $100^{\circ}$ ; it went up in the afternoon to  $103^{\circ}$ , and in the evening to  $104\frac{1}{2}^{\circ}$ ; later it was  $103\frac{1}{2}^{\circ}$ , and later  $104\frac{2}{3}^{\circ}$ . To-day it has varied from  $104^{\circ}$  to  $103\frac{3}{8}^{\circ}$ —a pretty steady temperature of  $104^{\circ}$ .

Dr. Loomis then said: "From this history can we make a diagnosis? We can—of typhoid or remittent fever. But does typhoid begin in the sudden manner and with severe and repeated chills? Occasionally; but not as a rule. And is the sudden rise of temperature noted yesterday typical of this fever? The German and the English writers lay great stress on a typical fever curve in typhoid fever as it is observed by them, but here in this country we observe it but occasionally. As a rule during the first week the temperature goes up and down suddenly several times, but with a steady rise withal; and during the second week it is usually about stationary. This temperature of  $104^{\circ}$  is not very high—would represent, perhaps, an average case. A stationary temperature can occur too in remittent fever: this usually takes place during, or later than, the third week, however."

Examining the patient, Dr. Loomis found his face flushed and not of the dark mahogany color of typhus, or having the bright red spot often seen in typhoid. There was



sordes on the lips and teeth and tongue, which is dry and brown as well.

The patient had also difficulty in protruding his tongue and also his acuteness of perception was apparently dulled. His pulse was 86 and of good quality. On the abdomen there was a profuse typical eruption, most of which appeared the day before, a few spots the day before and some this day. There was no distention, no tympanites, no tenderness and no pain in iliac fossa. There was gurgling, but this, Dr. Loomis said, is a symptom associated with many other conditions, and hence by itself of little diagnostic value. This absence of abdominal signs, however, should be looked upon as a good sign for the patient. It shows that, so far at any rate, the intestinal lesions are not severe and the dangers to the patient from complications from this source are very much lessened. The record shows that the patient had had two stools since his admission to the Hospital and that they were loose and light colored. The eruption, however, made the diagnosis positive, and it was needless to hunt for further confirmation, as it does not occur in any other disease. This was not a severe case, though it was yet too early in the disease to say that it will not prove to be one.

The treatment employed was milk diet and bismuth. Dr. Loomis believed this drug to be practically inert, and, as it is necessary to give something, it answers the purpose very well here. He had also applied the cold coil upon the abdomen. This will frequently reduce the temperature one or two degrees. There is no danger, however, from the present temperature of this man. It is but the expression of his disease, and as long as it remains where it is, nothing further will be done to reduce it.

Referring to cold baths and cold applications, Dr. Loomis said they had the sanction of the German, many of the French and some English authorities, and their reasoning and apparent results are very fascinating. He had tried them. He had used the bath slowly reduced to 60° until the patient's temperature had fallen three or four degrees; and repeated the procedure when the temperature became high again; but his experience, statistics and careful observations are against the use of the cold bath. He would not say he had killed patients by this method; but the fact remains, that they died; and he believed they did not do so well as those who had abso-

lutely no treatment in the manner of antipyretics. He does not believe these objections always applicable to the wet pack and cold sponging, and often uses these, provided they do not depress the heart or hurry the respiration, and do control the temperature for an appreciable time. But any procedure that will cause a small, fluttering, weak pulse, and increased effort in breathing must necessarily do harm.

In a simple case the chief care of the physician should be, to see his patient twice a day and watch for the appearance of complications; then not to drug him; and finally not to overfeed him. As a rule one quart of milk a day will be better than three. If the quantity is excessive it is undigested and it increases the diarrhoea.

#### Acute Bright's Disease.

The second case was one of a man, 36 years old; a drinking man, and a hard worker; who had been exposed to the weather by his occupation, which is that of a boatman. Three weeks ago, after a debauch, he discovered a swelling of his penis and scrotum, which came on suddenly. There was also difficulty in voiding his urine, which was of dark color and scanty—less than a pint in twenty-four hours. There was vomiting and some diarrhoea, but no headache, or disturbance of vision or pain in the back. On the following day his feet and legs began to swell, and, the vomiting continuing and his condition growing worse, he entered the Hospital ten days ago.

Examination showed well marked oedema of legs, and also of the scrotum and penis; some of the face, and some of the abdomen. The abdomen showed also enlarged veins. Both lobes of the liver were markedly increased in size. The spleen was somewhat enlarged, and the heart's apex was one inch to the left of the nipple. The first sound was indistinct and the area of dulness increased. There was a murmur at the base with the first sound, too rough to be anemic, which was observed on the day of the patient's admission. The pulse showed a very high arterial tension. Examining the lungs Dr. Loomis found behind and below feeble respiration and râles of oedema. The urine had a specific gravity of 1.025. It was slightly acid and precipitated half its bulk of albumin. It contained blood, and hyaline, epithelial, granular and blood casts.

This patient, Dr. Loomis said, was suffer-

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ing with acute Bright's disease, with the first stage of cirrhosis of the liver, and probably an old heart lesion. The important question was, whether, considering the condition of the heart, the arterial tension, and the slight improvement that the patient showed from treatment the acute inflammation be not grafted upon an old kidney lesion.

## PERISCOPE.

### The Acids of the Stomach.

There is no doubt that the chief acid found in the stomach during natural digestion is free hydrochloric acid. This has been abundantly proved by Bidder and Schmidt, and by numerous observers succeeding them. The methods used are, however, too long and too complicated to employ in clinical work. The physician wishes to know what, in a particular case of disease, are the chemical changes going on in the stomach; whether, for example, hydrochloric acid is present as well as pepsin and organic acids. Now, in the examination of the contents of a diseased stomach, three forms of acid may be present—hydrochloric acid, a mineral acid; organic acids, such as lactic acid, butyric, etc.; and thirdly, acid phosphates. It is chiefly of importance to determine the presence of hydrochloric acid and of organic acids. Many methods have been proposed for doing this; they consist mainly in testing the effect of the stomach contents on various colored solutions. Thus a solution of methyl-violet is decolorized by hydrochloric acid, so that if this reaction is obtained the free acid is present in the liquid tested. Lactic acid turns the violet a dirty yellow. Tropæolin also is turned deep reddish-brown by free hydrochloric acid. Unfortunately these tests, simple as they appear, are not accurate, since the reactions are interfered with by the presence of peptones and of some neutral salts, and, as these are usually present in the stomach contents, no reliable results can be obtained by using methyl-violet and tropæolin. They have been superseded by Congo red, which is turned blue by free hydrochloric acid, and by a solution of vanillin and phloroglucin in alcohol, which is turned a deep red by the same acid. These simple clinical tests are, however, rendered useless by the fact that they are

interfered with by the presence of peptone, ammonium salts, chlorides, and phosphates.

In the present state of our knowledge, therefore, there is no reliable indicator for the presence of free hydrochloric acid in the stomach contents. Other methods which may be used are too complicated for clinical use. Thus ether has the property of dissolving organic acids from a liquid, leaving the mineral acids in solution. It may thus be used for separating the lactic, butyric, and other acids from the hydrochloric acid; and if in a liquid obtained from the stomach it is found that ether removes the whole of the acids present, it may be concluded that no free hydrochloric acid is present. In many cases this conclusion would be an important one as a clear indication for a line of treatment. Dr. Leo has lately published a new method for the indication of free hydrochloric acid which may prove useful. Leo considers the case where it is only a question of the presence of free hydric chloride and of an acid phosphate. To a few drops of the stomach contents a pinch of carbonate of calcium is added; if the acidity, as tested by litmus paper, disappears, only a free acid is present, but if the liquid is still acid after the addition of the chalk, an acid salt is present. If, moreover, organic acids be present they must be first removed by shaking with ether before the chalk is added. It does not seem that Leo's method is one that can be applied at the bedside, because the detection of free hydrochloric acid is chiefly requisite in those cases in which organic acids are also present, as in cases of dilated stomach. At present, indeed, a ready method, suitable in clinical practice for the detection of free hydrochloric acid in organic liquids, is a desideratum.—*British Med. Journal*, Oct. 5, 1889.

### Anæsthesia.

The subjects of selection and methods of use of anæsthetics, the danger of anæsthesia, and the treatment of the accidents which occur during it, have been so much discussed, indeed, so hackneyed, that we almost feel like apologizing for alluding to it. The matter is one, however, of the greatest importance, and the reporter of a case of death from ether, in the *New York Medical Journal* of May 18, held that the knowledge of physiological therapeutics has not yet been thoroughly diffused through the rank and file of the profession. In this case a

middle-aged Frenchman, who had been suffering from tubercular disease, with albuminous urine, and aortic and mitral systolic murmurs and feeble heart-sounds, was given ether with the intention of the performance of Syme's amputation. A few moments after etherization was commenced the respiration faltered, and the patient became deeply cyanosed. This somewhat alarming condition quickly passed away, and five minutes later the assistant having the pulse under observation suddenly announced that it had ceased. "Immediately hypodermic injections of brandy, ether, and sulphate of atropine were given; amyl nitrite was applied to the nostrils, artificial respiration was practised, and the head and shoulders were depressed by elevation of the foot of the table; but all was in vain; the patient was dead."

According to the surgeon in charge who reports the case, the death was the result of syncope, and largely the outcome of the diseased condition of the heart, which was found at the autopsy to have a completely adherent pericardium, atheroma of the aorta, and stenotic mitral valve. The kidneys were also in a condition of advanced contraction.

In the first place, it is essential that a case like this be not allowed to go upon record as one of death due to ether. We doubt very much the wisdom of attempting a severe surgical operation like amputation of the foot in a man who has disease of the kidneys, disease of the mitral and aortic valves, and the other numerous organic ills which affected this Frenchman. If an operation was justifiable at all in such a case, both the surgeon and patient should appreciate the excessive risks, and no therapist should charge the death against the anæsthetic. The peculiar greatness of the danger in the case becomes manifest when the selection of the anæsthetic is thought of. The condition of the kidneys strongly contraindicated the use of ether; the clinical evidence which we now have being enough to demonstrate that chloroform is safer than ether in cases of renal disease, unless the heart-muscle has undergone secondary degeneration. This is probably because the amount of chloroform required to produce anæsthesia is so much smaller than that of ether that less strain is thrown upon the organ that eliminates it, hence the diseased kidneys are less irritated by chloroform than by ether. On the other hand, in the case under consideration the condition of the heart evidently contraindi-

cated the use of chloroform; in fact, both ether and chloroform were contraindicated, and nothing but the gravest necessity could justify their use.

It is especially, however, to the treatment employed that we want to call attention, and we have no hesitation in affirming that if the patient had any chance of recovery at all, such chance was destroyed by the methods used for his relief. Suppose a doctor, having a case of opium-poisoning to deal with, were, for the purpose of relief, to administer morphine hypodermically, what would be the judgment of the profession as to the method? Evidently that it was a madness. But here we are told that hypodermic injections of ether and brandy were given. Probably almost every one in the profession would agree with us in believing that the use of hypodermic injections of ether was improper; possibly only a minority would agree to the statement that the administration of the brandy was almost, if not quite, as dangerous. Ether and alcohol, are, however, chemically almost identical; physically, except in the matter of volatility, they are exceedingly alike, and in their relations to the human organism they seem to differ only in so far as one is more volatile, and therefore more quick and more fugacious in its action than the other. Each primarily stimulates and secondarily depresses the heart, and we believe that in accidents of etherization the administration of alcohol is equivalent to the administration of more of the poisonous agent. This conclusion rests also not simply upon a *priori* argument. As long ago as 1883, R. Dubois, in a series of experiments made upon the lower animals, found that the free administration of alcohol intensifies the influence of chloroform and lessens the minimum fatal dose. Certainly alcohol and ether are more nearly equivalent remedies than are alcohol and chloroform.—*Therapeutic Gazette*, July, 1889.

### Protection of the Health and Life of Infants.

Landouzy and H. Napias state, in a communication in the *Bulletin Medical*, September 4, 1889, that the mortality among children is frightful in every country, especially in the first twelve months of life; it may reach, in this period, as high as 34 per cent., or more than one-third. To remedy this we must know the complex

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causes of the mortality. They offered the following propositions for consideration by the Congress on Hygiene which met in Paris last summer. 1. In all countries a uniform method should be adopted for recording the statistics of mortality in infants. These statistics should follow the history of children from year to year, from birth up to the fifth year. 2. The registration of the deaths of children should be made only after a vigorous investigation covering the following points: The nature of the disease which has caused death; the exact date of birth; the method of feeding; by the breast or bottle, or both, or on other kinds of nourishment; the character of the milk; the transmissible diseases which may have affected the parents or care-takers; and the healthfulness of the lodgings occupied by the parents or nurses. 3. Every legal measure, administrative or private, which will favor the nursing of children by their mothers, will promote the hygiene of children. Artificial feeding is the surest of all the means of contagion for infectious diseases. This explains why bringing up children exclusively on the breast gives them— all things being equal—a good chance of surviving. In cases in which nursing by the mother is impossible, that mode of artificial feeding should be encouraged which will give the greatest guarantee against the transmission of morbid germs; a bottle should be chosen, and all measures adopted to assure the non-contamination of the milk. 4. It is expedient that proper notions of infantile hygiene should be spread abroad by all possible agencies, in the cities and in the country; they should be imparted to girls in the primary school; and in the large cities especially should there be annexed to the primary schools day nurseries in which young girls, in the last two years of schooling, could take practical care of infants. 5. In industrial cities every measure taken to diminish the working hours of women in the shops and factories will be a hygienic measure of which children will naturally reap the benefit.

#### Beta Vulgaris for Habitual Constipation and Hemorrhoids.

Dr. S. Kazatchkoff states, in a communication to *Meditzina*, No. 6, 1889, that the common beet is a popular remedy in central Russia to overcome atonic constipation and hemorrhoids. It is given in the form of a

decoction, in doses of a half-cup to a cupful daily; it is said to cause neither colic nor digestive disturbances, nor to be followed by constipation. The patient, however, becomes accustomed to the remedy after using it a week, and the dose has to be increased. Nevertheless, Kazatchkoff attributes to it greater virtues than to castor oil, rhubarb, magnesia, podophyllum, and to the mineral water purgatives.—*Gazette Hebdomadaire*, September 27, 1889.

#### Treatment of Purpura Hemorrhagica with Nitrate of Silver.

Dr. Poulet has a communication on the treatment of purpura hemorrhagica with nitrate of silver, in the *Bull. gén. de Thérap.*, May 30, 1889. The author relates two characteristic and severe cases of purpura hemorrhagica, which promptly recovered when nitrate of silver was given internally. The first was that of a boy, 12 years of age, with a family history of tuberculosis and albuminuria, who, eight days previously, had been attacked by a petechial eruption, culminating in profuse epistaxis, which rapidly reduced him to a bloodless condition. Poulet ordered tincture of the chloride of iron and the acid infusion of roses, and, as this did not check the hemorrhagic tendency, he followed it up on the following day by plugging the nostrils and giving subcutaneous injections of ergotine. The bleeding, however, continued as before, and the condition of the patient became critical. He then resorted to nitrate of silver, in doses of one-fifth of a grain, twice a day, incorporated with bread-crumbs and given after food. The next day a manifest improvement had taken place, and in the course of three or four days the drug could be discontinued. The lad gradually recovered, but the loss of blood had been so abundant that it was years before he ceased to be delicate and anemic. The second case was that of a young woman 20 years old. Eight days after her last menstrual period purpuric spots made their appearance, with frequent attacks of bleeding from the nose, stomach, and bowels. She was fairly well nourished, and lived in the open country. Her previous health had been good, but for some weeks past she had experienced a feeling of lassitude, with loss of appetite. The eruption was most marked at first on the lower extremities, but soon

became general. Various anti-hemorrhagic remedies were tried, but without any marked effect on the bleeding. There was slight albuminuria; legs a little puffy. Under these circumstances he ordered one-eighth of a grain of nitrate of silver in a pill, three times a day. The effect was so marked that within four days sight and hearing were restored, and the purpuric patches began to fade. The hemorrhages ceased after the first day of the exhibition of the nitrate. Twelve pills in all were taken, and they sufficed to effect a cure.—*London Medical Recorder*, June 20, 1889.

### Pea-Soup as a Substitute for Beef-Tea.

Dr. Ris of Kloten, Switzerland, says *The British Medical Journal* of Sept. 28, emphatically recommends pea-soup as an excellent substitute for beef-tea for invalids, convalescents, and more especially for patients suffering from cancer of the stomach, or *diabetes mellitus*. Take peas, water, and sufficient amount of some vegetable suitable for soup, and one-half per cent. of carbonate of soda, and boil the whole until the peas are completely disintegrated; then let the soup stand until sedimentation is complete, and decant the fairly clear, thin fluid above the deposit. The product is stated to resemble a good meat-soup in its taste, to be at least equally digestible, and at the same time to surpass the very best meat-soup in nutritive value. The latter statement may appear surprising, but the author reminds us that peas (as well as beans or lentils, either of which may be used instead of peas) contain a considerable portion of legumen; that is, a vegetable albumin which is easily soluble in a faintly alkaline water, is not coagulated by heat, is easily absorbed, and equal to the albumin of eggs in its nutritiousness.—*Science*, Oct. 18, 1889.

### The Treatment of Abdominal Aneurism.

A novel procedure was attempted by Mr. Keetley in a case of large abdominal aneurism under his care at the West London Hospital. The tumor, which mainly occupies the epigastric region, and projects prominently forwards, had thrust the liver into the right lumbar region, and Mr. Keetley, in order to control if possible the pulsation in

the aneurism, devised and carried out the following procedure: An incision was made below the ribs on the right side, and the peritoneal cavity opened; a specially constructed instrument with a handle, a curved stem, and a thickened extremity was then passed into the wound and through the foramen of Winslow, between the liver and the tumor, and made to compress the aorta above the origin of the coeliac axis. Upon the first occasion the stem was of copper, and unfortunately bent under the pressure to which it was subjected. The operation was repeated with an instrument constructed of steel. It was found that the object aimed at could be obtained, but not entirely. Although the aorta was by this means partly compressed, it was not possible to control the circulation sufficiently to render it justifiable to continue the attempt. However, Mr. Keetley is satisfied with the feasibility and the ultimate utility of the procedure, and its non-success in the present instance is doubtless largely due to the immense size of the tumor preventing even the fingers from reaching the aorta above the disease, and disturbing the normal relations of the parts.—*Medical Press and Circular*, June 12, 1889.

### Thirty Years in a Man's Body.

Dr. Nisson relates, in the *Magdeburger Zeitung*, the following case which has come under his observation: "I have just extracted," he says, "from the arm of a patient of mine, an iron-founder, a darned needle seven centimetres long, which was embedded in a muscle (the *triceps brachii*). The needle was completely black from oxidation, and had for years caused great pain to the patient, who was supposed to suffer from rheumatism in various parts of the body, and had been treated for that disease by numerous doctors without success. As the man has no recollection of a needle running in him, it is probable that it must have done so in his early childhood, and that it had been traveling about his body for some thirty years before it was discovered. It is worthy of note that when he was two years old he was treated for some months for disease of the spine, the appearance of which disease may have been caused by the presence of the needle in the neighborhood of the spine, and the irritation consequently set up."—*Philadelphia Ledger*, Oct. 19, 1889.

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# THE MEDICAL AND SURGICAL REPORTER.

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CHARLES W. DULLES, M.D.,

EDITOR AND PUBLISHER.

N. E. Cor. 13th and Walnut Streets,  
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## ANÆSTHETICS AND ACCIDENTS.

A few weeks ago a well-known citizen of Philadelphia, in the prime of life, died suddenly after having been anæsthetized with nitrous oxide gas in order to have a tooth extracted painlessly. He did not die while under the anæsthetic; but, soon after he recovered consciousness, he had symptoms of apoplexy, which increased until he died, after a lapse of a few hours. He was a man of large frame, of excellent general health and vigor, and of unexceptionable habits of life. The Coroner's investigation which followed did not include an autopsy, and so the immediate cause of death was not certainly known, but the diagnosis of apoplexy seems to have been justifiable.

This is an extraordinary case—and fortunately a very rare one—of death following soon after anæsthesia with nitrous oxide gas.

No one, we believe, has asserted that in this case the anæsthetic directly caused death, and the general opinion seems to be that it was a mere coincidence. This opinion we cannot agree with unconditionally; for we cannot but believe the condition of nitrous oxide anæsthesia started the train of changes which culminated in apoplexy—if this was really the immediate cause of death.

Still, it may be said that accidents following anæsthesia with nitrous oxide gas are almost as rare as phoenixes, and scarcely to be named in contrast with its beneficent effects. The same may be said of ether and chloroform; although in their case danger and death are by no means uncommon.

Justice to the truth requires that all the circumstances attending a case of death during or soon after anæsthesia should be known and duly estimated before deciding in how much the result is fairly chargeable to the anæsthetic. In a case reported in the *British Med. Journal*, Oct. 5, 1889, a woman in Birmingham, twenty-five years old, of very nervous and excitable temperament, desired to have some teeth extracted, and insisted upon being anæsthetized. In the presence of her husband and the dentist, her medical attendant administered chloroform. The patient was seated in an easy chair, and, after inhaling a few breaths of chloroform, she slipped down in the chair, and her pulse and breathing stopped. Artificial respiration was at once resorted to, but without success. It seems perfectly clear that the patient was not anæsthetized when she died, as she had only just commenced to inhale the chloroform, and, of course, no attempt had been made to extract her teeth. The Coroner's jury returned a verdict that death was due to syncope, and that no blame whatever attached to the administrator. In commenting on this case, our British contemporary very truly says that it is well known that syncope may result from violent emotion, and especially from the effects of fear. It repeats the story of a case recorded in Germany a few years



ago in which a female patient visited a dentist, and requested him to extract some carious teeth, demanding, at the same time, that she should be chloroformed. The dentist explained the risks of chloroform, and suggested nitrous oxide gas; but his patient persisted, and he pretended to humor her. Having, however, a wholesome dread of chloroform, he substituted Cologne water, and bade her inhale the supposed anæsthetic from a folded towel. After two or three inspirations she suddenly fell from the chair, and died.

Such stories as this indicate that it would be but hasty and ill-considered judgment to look no further than to the anæsthetic to explain deaths which at first sight might seem chargeable to it. They indicate at the same time dangers connected with the administration of anæsthetics which are all the more serious because they are rarely encountered, and perhaps never anticipated. Due consideration of them, therefore, may serve a double purpose—in diminishing, as well as defining, the elements of real danger in anæsthesia.

#### CHLORALAMIDE, THE NEW HYPNOTIC.

Several recent papers upon the new hypnotic, chloralamide, make it possible to give briefly its more important properties and effects. It is formed by the addition of chloral anhydride to formamide, and is found as colorless crystals, having a slightly bitter but not disagreeable taste. According to Drs. Hagen and Hüfler, in a communication to the *Münchener med. Wochenschrift*, No. 30, 1889, the effect of the drug begins in about one-half hour after its administration. In most cases thirty grains are sufficient for a dose, but forty-five grains may be given without hesitation. Hagen and Hüfler give notes of twenty-five cases in which chloralamide was employed; in most of these the patients were suffering with grave organic diseases. A hypnotic effect

occurred in twenty of the patients, and in sixteen it was perfect. The remedy failed to act only in the case of a paralytic, and in a patient strongly consumptive. The sleep produced is described as quiet. Only eight of the patients complained of slight headache on awaking, while the rest felt entirely well. Patients do not appear to become accustomed to the drug readily; for it is stated that, when frequently employed in the same patient, its good effects continued, and no disagreeable secondary effects were seen. It is noteworthy that the remedy also acted well when the sleeplessness was due to violent pain, and that the healthy patients, who were given it in the morning without anything being said to them, slept the whole day with short interruptions, and also enjoyed their usual good sleep the following night.

Dr. Eduard Reichmann, in a paper published in the *Deutsche med. Wochenschrift*, No. 31, 1889, confirms the experience of the authors just quoted in a very satisfactory manner. As regards the dose, he states that fifteen grains was uncertain in its effects, but that thirty grains was nearly always successful. Reichmann makes the highly important statement that he observed the behavior of the pulse especially, and that chloralamide exerted no recognizable influence upon the heart and vascular system—in agreeable contrast, therefore, with the effect of chloral.

The experience of Erich Peiper (*Deutsche med. Wochenschrift*, No. 32, 1889), is also in the main confirmatory of that of the other experimenters referred to. Disagreeable symptoms, however, consisting of headache, dizziness and weariness, were observed by him somewhat more frequently. Peiper nevertheless prefers chloralamide to chloral.

Finally, Dr. Rabow has a short communication on chloralamide in the *Centralblatt für Nervenheilkunde*, No. 15, 1889. He also reports good results from the new remedy; in nervous sleeplessness and in the sleeplessness of alcoholics, somewhat larger doses—sixty grains—were employed. In

excited and maniacal patients, however, it did not act.

Many new hypnotics have been offered to the profession in recent years. Most of them are useful under special circumstances, and almost all are found sooner or later to have peculiar disadvantages. Perhaps the attitude of the practitioner should be to try all, and to "hold fast to that which is good." The present hypnotic, chloralamide, appears to have certain advantages. It is cheap, the dose is small, it may be given in capsules or in solution, and its taste is said not to be disagreeable. If given in solution the water should not be too warm—not over 140° Fahr.—as otherwise the chloralamide is decomposed and becomes inactive. It is to be hoped that later experience will substantiate that already given, especially with regard to the harmlessness of the remedy.

#### OPERATIONS FOR GOITRE.

It is not many years since operations upon the enlarged thyroid gland were regarded with well-founded dread by almost all surgeons. The dangers of cutting operations for goitre were so great and the mortality so large that little was done for the relief of this disfiguring and distressing disorder beside injecting the tumor with iodine or occasionally some other so-called absorbent. This condition has been changed, largely through the persistent devotion of Kocher, of Bern, who has for some years steadily studied and practiced operations upon the thyroid gland. The result of this work is shown in a report on 250 operations published originally in the *Correspondenz-Blatt für Schweizer Aerzte*, and summarized in the *Memorabilien*, September 13, 1889. The report covers five years and a half of Kocher's experience, and presents results worthy of the most careful attention.

In the first place—as Dr. Betz points out—it appears that in Kocher's hands the statistics of extirpation of the thyroid have become so favorable that its mortality is no longer

a serious feature. In only six of Kocher's two hundred and fifty extirpations did death follow—that is, in only 2.4 per cent.; while in three of the fatal cases the disease was malignant, and one was a case of Graves' disease. If these cases be eliminated from the total, the mortality is reduced to *eight-tenths of one per cent.* Even this result appears in a more favorable light when one learns that, in one of the remaining fatal cases, the patient was probably poisoned with ethylene, while the other patient was brought to the clinic almost moribund, in extreme dyspnoea.

In the main, Kocher adheres to the method associated with his name. The Winkel curved incision is preferred for difficult cases and when the thyroid is large; while for simpler tumors the oblique incision at the anterior border of the sterno-cleido-mastoid muscle, with a preference for the transverse incision, which does not give as good access to the field of operation, but from a cosmetic point of view is said to give the most beautiful results. The recurrent laryngeal nerve, and the principal trunk and the branches of the sympathetic, are most likely to be wounded. Tying the inferior thyroid artery must be done with the greatest care. In regard to later results of extirpation of the thyroid, it seems that what was once known as *cachexia strumipriva* might be more correctly called "*cachexia thyreopriva*," and it seems important that in every extirpation of the thyroid gland some portion shall be left behind. Kocher, who is the best judge of such matters in the world, says that extirpation of the thyroid is indicated, first, in malignant disease if the disease is not diffuse, and also in cases in which there is a well-founded suspicion of malignancy; second, in inflamed thyroids which are free from cysts; third, in diffuse so-called hypertrophies. The contra-indication to extirpation is the absence of healthy gland substance upon the other side.

Enucleation is indicated, first, in cystic thyroids—that is to say, in cases in which cysts form the principal part of the tumor;

second, where there are large isolated nodules imbedded in relatively sound glandular tissue; third, in immovable thyroids containing large nodules.

Scraping out (*évidement*) is indicated, first, where there are isolated nodules of soft consistence in relatively sound gland tissue; second, in cases such as those noted under the indications for enucleation, if there are nodules of soft consistence and with free and numerous vascular connections in the neighborhood.

Resection (partial excision) of the thyroid takes the place of extirpation and enucleation in the numerous cases which do not sharply correspond to the above indications. Ligation of the thyroid arteries should be performed in vascular thyroids, especially in Graves' disease.

Taken as a whole, we can heartily commend to the notice of our readers the views of Kocher on this important subject. No place in the world affords such full opportunities of studying it as he enjoys, and his wonderful success gives his opinions a weight which cannot attach to those of any operator less experienced and less successful.

#### CARBONIC ACID IN PULMONARY CONSUMPTION.

It is a well-known fact that diabetes and pulmonary consumption are very intimately associated, the one with the other; and, according to Ebstein, the carbonic acid production is markedly lessened in quantity in the former disease. Animated by the belief that the partial absence of carbonic acid is conducive to the growth of the tubercle bacilli, and that this anomaly sustains a causative relation to phthisis, Dr. Hugo Weber advocates the administration of this gas in the treatment of this disease in the *Berliner klin. Wochenschrift*, Sept. 2, 1889. He gives one teaspoonful of sodium bicarbonate before each meal, immediately after a glass of water containing twelve drops of muriatic acid has been taken. About half

a pint of gas is generated by this procedure which is believed to be exhaled through the lungs, and to have a germicidal influence on the tubercle bacillus.

He reports ten cases of consumptives subjected to this plan of treatment, and it is encouraging to learn that all derived benefit—even those in whom the destructive processes in the lungs had advanced to an extreme degree. It is especially noticeable that the improvement took place while the patients remained in the same general conditions to which they had been subject before—that is, they were not taken to hospitals or treated in any way which could throw doubt upon the part in their improvement from Dr. Weber's method.

#### UTERINE DISPLACEMENT AND PREGNANCY.

It is generally believed that retroflexion and retroversion of the uterus predispose to sterility by reason of the failure of the spermatic fluid to enter the displaced os and cervix, and that, when pregnancy does occur, it very soon becomes complicated by the incarceration of the enlarging uterus. New light has been thrown upon this subject by recent investigations by Professor Martin, of Berlin, who found in the records of his clinic in Berlin, 121 cases of persistent retroflexion of the pregnant uterus in a total of 24,000 patients. In 27 of these cases the deformity of the uterus was congenital, and was complicated with endometritis and by affections of the tubes and ovaries; but even under these unfavorable circumstances, conception occurred. Even gonorrhœal infection, so commonly believed to cause sterility, failed in one case to prevent conception, although accompanied by retroflexion. Martin draws the very practical conclusion that it is not the uterine deformity, but a coincident catarrhal or inflammatory state of the endometrium or tubes, which causes sterility in these cases. Congenital retroflexion alone does not prevent conception.

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The usual belief that pregnancy and parturition correct uterine deformity was disproven by ninety-four cases, in which repeated pregnancy failed to remove it: nine of these patients had been under treatment for misplacement and were wearing pessaries when conception occurred. A ready explanation of the fact that the family physician meets so few cases of pregnancy in persistently retroflexed or retroverted uteri arises from the frequent occurrence of spontaneous reposition. As the womb enlarges nature lifts it above the pelvic brim in nearly all cases. The most common symptom, warning the attendant that such is not the case, is frequent and difficult urination, for which he finds no other cause. This should lead to careful examination, and to efforts at reposition in the knee-chest position. Should irreducible incarceration result, spontaneous or induced abortion may solve the problem. But this failing, and the womb remaining fixed, this organ may be removed through the vagina if small, or amputated above the pubes, as in the Porro operation. Martin's article in the *Deutsche Medicinische Wochenschrift*, Sept. 26, 1889, and a case reported by Sperber in the *Centralblatt für Gynäkologie*, No. 36, 1889, and a method of reposition described by Cohnstein, in the *Archiv für Gynäkologie*, Band xxxiii, Heft 1, furnish interesting recent literature on this subject to those who may wish to pursue it further.

## BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

**HYPNOTISM: ITS HISTORY AND PRESENT DEVELOPMENT.** BY FREDRIK BJÖRNSTRÖM, M. D., Head Physician of the Stockholm Hospital, etc. Authorized translation from the second Swedish edition by Baron Nils Posse, M. G., Director of the Boston School of Gymnastics. 8vo, pp. iv, 126. New York: The Humboldt Publishing Co. Price, 30 cents.

This interesting book contains a scholarly account of the history, development and scientific aspect of hypnotism, covering the manifestations of this condition in ancient and modern times. It describes the popular and unworthy exhibitions of this curious phe-

nomena which formerly prejudiced the scientific world against its careful investigation, and which in the present day serve the purpose of charlatans; and, equally, it describes the steps by which its manifestations have come to be better classified—if not much better understood than when they were used by Egyptian priests or Indian fakirs. In doing this the author speaks of the use of hypnotism as a therapeutic agent, and the possibility that it may be used for immoral and illegal purposes. In conclusion he urges that the law should restrict the use of hypnotism, as a method which may be dangerous to the medical profession.

As a whole, the book is of great interest and very instructive. It is worthy of careful perusal by all physicians, and contains nothing unfit to be read by the laity.

**THERAPEUTICS FOUNDED UPON ORGANOPATHY AND ANTIPRAXY.** BY WILLIAM SHARP, M. D., F. R. S., etc. 8vo, pp. 203. London: George Bell & Sons, 1886.

One accustomed to the work of reviewing who takes up a book of this kind is tempted to condemn it at once, on its title alone. We doubt if many critics could be found whose experience did not make them regard with suspicion any volume bearing such singular words on the title-page. Still, if the critic be one who regards with favor every attempt to do good in writing books, he does not allow his objections to strange theories and curious modes of reasoning to blind him to motives which are worthy of praise. So, in going through the book, we have not failed to discover the author's manifest wish to be of service to his fellow-men, and his conviction that what seems to him a great truth ought to be communicated to them. This fact makes us lenient toward one who deliberately asserts that almost all medical literature is loaded down with error, and gravely suggests that his views may "do for Medicine what Sir Isaac Newton's law of gravitation has done for Astronomy." But this is the most that we can say; for his book as a whole strikes us as the extravagant production of a mind too conscious of its own operations and too indifferent to those of other men equally sincere and of greater scientific reputation. Those who have time to read such a book will find in this one much that is interesting and much that is suggestive, but this is mixed with much that is repellant from its lack of modesty and much that will appear to most readers as absolutely foolish. The author may have meant well in writing all this, but he is not likely to gain such fame as Newton did—nor is any one who could use the language of Lord Bacon in regard to the stagnation of medical science as if it were applicable in the present day.

**A SYSTEM OF OBSTETRICS BY AMERICAN AUTHORS.** EDITED BY BARTON COOKE HIRST, M. D., Assoc. Prof. of Obstetrics in the Univ. Penna., etc. Vol. II. Illustrated with 221 engravings on wood. 8vo, pp. xi, 854. Philadelphia: Lea Bros. & Co., 1889. For sale by subscription only.

This volume completes the most important recent addition to the literature of gynecology and obstetrics. The profession in America may well feel proud of what has been accomplished by the contributors and editors.

The present volume of the system of Obstetrics treats of those subjects which are of the greatest interest to the practitioner—the accidents and diseases incident to parturition and the puerperal state; and

their treatment, prophylactic, surgical and medical. Our space forbids a review at length, but we are glad to be able to say that the work is of the highest order. The most striking feature of the book is the space devoted to inculcating the value of antiseptic midwifery. This teaching is set forth admirably, and should be carefully considered by all who are engaged in this important field of medical practice.

## CORRESPONDENCE.

### Night Terrors of Children.

TO THE EDITOR.

*Sir:* In addition to your judicious editorial comments on this subject, in the *REPORTER*, Oct. 12, 1889, allow me to suggest a factor in the etiology that seems to have eluded observation. From some experience in my own family, I am led to suspect that quite often the malady may be due to a closely fitting night-dress. I observed in the case of my own child, that whenever the night-dress was buttoned tightly about the throat, she was sure to have an attack of night terrors; and that she never had them when the throat was left free and open. In certain positions of the head, the neatly fitting band would occasion constriction of the throat, whence arose mechanical congestion of the brain, which gave rise to the "terrors."

A night-dress, closely fitting around the throat, is a vicious thing, and gives rise to cerebral congestions which may suddenly explode in a convulsion, but much oftener, I apprehend, take the form of night terrors.

Yours truly,

J. P. HASSLER, M. D.

Meadville, Pa.,

Oct. 16, 1889.

### Union of Cut-off Fingers.

TO THE EDITOR.

*Sir:* I notice in the *REPORTER*, Oct. 5, mention of the reunion of a cut-off finger. During my term in the Dispensary of St. Mary's Hospital, last summer, a man about fifty years old walked in with several of his fingers badly injured, one requiring amputation at the proximal inter-phalangeal articulation. The forefinger just below the distal articulation was cut through with the exception of about an eighth of an inch of skin and fascia, and was hanging loose. I was thinking seriously of completing the amputation, when the patient suggested that he

had a finger nearly cut off some years before, and it had been sewed on and grown fast; so, as the cut was a very clean one, I washed the wound well with bichloride solution, and joined the parts with silk stitches without any drainage. The two surfaces united rapidly, and the man has now a useful finger, the only evidence of the injury being an increased circumference due to callus thrown out, and a slight scar. There is no doubt that great numbers of useful fingers are annually sacrificed owing to a too free use of the knife. A little more conservatism in this branch of minor surgery is badly needed.

Yours truly,

A. HAMILTON DEEKENS, M. D.

St. Mary's Hospital, Philadelphia,  
Oct. 8, 1889.

## NOTES AND COMMENTS.

### Plagiarism.

The *Lancet*, Oct. 5, 1889, makes the following handsome acknowledgment in regard to an imposition practiced upon it by a contributor to its pages:

It is, we believe, happily a rare thing for a contributor to this or any other medical journal to adopt as his own "original" contribution the writings of another author. Such, however, we regret to say, has been the case with respect to a paper contributed to these columns by F. W. Allwright, M. D., L. R. C. S. I., entitled "The History and Use of Anæsthetics in Midwifery" (1889, vol. i, pp. 983, 1239; vol. ii, p. 589), which, as our contemporary the *Medical News* (Philadelphia) points out, is practically a transcript of certain pages of the valuable article upon that subject contributed to "Hirst's American System of Gynecology and Obstetrics," vol. i, by Dr. J. C. Reeve. The first volume of the "System" had been in our possession many months, but had not come up for critical notice, as we felt it would be more convenient to review the work as a whole, after the issue of the second volume, which has lately come to hand. Hence our failure to recognize the near identity of the two articles in question. We have communicated with Dr. Allwright, . . . who admits that his paper "obtained its foundation from" Dr. Reeve's article, but who does not seem to be aware

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of the gravity of the charge of plagiarism which has been fully substantiated against him. Nor does he even apologize to us for having used our pages as a medium for the publication of his unacknowledged transcript. We therefore feel bound to notice the matter thus publicly, and to express to our readers and also to Dr. Reeve our regret that the paper in question appeared in our columns. It is obvious that every journal must have complete confidence in its contributors, and that it is practically impossible to guard against such a practice as that referred to, which for the credit of our profession is, we are sure, of unusual occurrence.

### The Dread of Death.

Sir Lyon Playfair, in a letter to Junius Henri Browne, author of a paper with the above title, says: "Having represented a large constituency (the University of Edinburgh) for seventeen years as a member of Parliament, I naturally came in contact with the most eminent medical men in England. I have put the question to most of them: 'Did you, in your extensive practice, ever know a patient who was afraid to die?' With two exceptions they answered, 'No.' One of these exceptions was Sir Benjamin Brodie, who said he had seen one case. The other was Sir Robert Christian, who had seen one case, that of a girl of bad character who had a sudden accident. I have known three friends who were partially devoured by wild beasts under apparently hopeless circumstances of escape. The first was Livingstone, the great African traveler, who was knocked on his back by a lion, which began to munch his arm. He assured me that he felt no fear or pain, and that his only feeling was one of intense curiosity as to which part of the body the lion would take next. The next was Rustem Pacha, now Turkish ambassador in London. A bear attacked him, and tore off part of his hand, and part of his arm and shoulder. He also assured me that he had neither pain nor fear, but that he felt excessively angry because the bear grunted with so much satisfaction in munching him. The third case is that of Sir Edward Bradford, an Indian officer now occupying a high position in the Indian office. He was seized in a solitary place by a tiger, which held him firmly behind the shoulders with one paw, and then deliberately devoured the whole of his

arm, beginning at the end and ending at the shoulder. He was positive that he had no sensation of fear, and thinks that he felt a little pain when the fangs went through his hand, but is certain that he felt none during the munching of his arm."—*Science*, Oct. 18, 1889.

### Treatment of Pruritus Vulva.

Dr. Percy Newell recommends the following lotion for pruritus vulvæ:

R Acid. Carbolicæ . . . . . gr. xvi  
Tr. Opii . . . . . f 3 ss  
Acid. Hydrocyan. dilut. . . . . f 3 ii  
Glycerini . . . . . f 3 ss  
Aqueæ destil. q. s. ad. . . . . f 3 iv

M. Ft. lotio.

Dr. Scanlan recommends the following:

R Cocain . . . . . gr. i  
Lanolin . . . . . 3 i

M. Ft. unguentum.

### Prevention of Attacks of Migraine.

Dr. Hammerschlag, according to the *Allgemeine med. Central-Zeitung*, No. 39, employs the following combination of remedies for the prevention of attacks of migraine, and states that hitherto it has not failed him:

R Caffeinæ citrat. . . . . gr. xv  
Phenacetin . . . . . gr. xxx  
Sacch. albi . . . . . gr. xv

M. Fiat. pulv. Dis. in capsulas No. X.

Sig. One capsule to be taken, in the intervals of the attacks, every two or three hours.

Phenacetin, he says, does not act so promptly when given alone. This treatment may be kept up until a decided remission occurs, and this does not have to be waited for long.—*Wiener med. Presse*, June 2, 1889.

### Etiology and Treatment of Acne.

Barthélemy says, in the *Bulletin Médical*, September 1, 1889, that in acne there exists habitually some dyspepsia, some dilatation of the stomach and divers symptoms connected with it; and that it is only in treating the digestive troubles that one can finally make himself master of the cutaneous affection and have some chance of preventing the provoking relapses. Dyspepsia, however, acts only by preparing the soil



upon which the germ of acne will be sowed and will develop. The germ finds a truly favorable medium only in seborrhœa. This affection is the direct consequence of defective elaboration of food in the stomach, of abnormal fermentations which it undergoes, and of elimination by the glands of the skin of all these products, otherwise toxic—leucomaines, volatile fatty acids, etc., which have been absorbed with the useful products of digestion. According to Barthélemy, there is no acne without preceding seborrhœa. The acne eruption is the result of a sowing of the seborrhœic skin with germs which come from the exterior. These adhere to the skin more readily on account of its oily condition. Barthélemy declares that the eruption is contagious and antio inoculable from contiguous points. That is to say, it is transmissible from one individual to another, on condition of its meeting with a seborrhœic soil; but it is transmitted especially on the same individual from one sebaceous gland primarily infected to other sebaceous glands. Acne is, therefore, to be reckoned among the parasitic affections, along with ecthyma, furuncle, impetigo, etc. The eruption will be discrete or confluent according to the condition of the organism affected, whether depressed or not, and also according to the existence of a more or less seborrhœic condition of the skin. The germs seem, at times, to occupy the skin and remain in a latent condition, to develop anew when a favorable occasion arises.

Treatment—apart from surgical means, which are indicated exceptionally—should consist in cutaneous antiseptics, to combat the germs; and also in gastro-intestinal antiseptics, to render the organism refractory to new attacks by sterilizing the culture medium.

#### Unfortunate Result of Whitehead's Operation for Hemorrhoids.

Dr. Charles B. Kelsey, reports in the *N. Y. Medical Journal*, Oct. 5, 1869, the history of a patient brought to him a few days before by Dr. Peckham: A woman, aged thirty-five, had been operated upon eight months before in one of the N. Y. city hospitals for hemorrhoids by Whitehead's method. On examination, the anus presented a circle of excoriated mucous membrane ending abruptly in healthy skin. The mucous membrane, which had been drawn outside of the rectum

and united to healthy skin, was an inch broad for one-half the circumference of the anus and half an inch broad for the remainder. In other words, the circular incision in the operation was entirely outside the margin of the anus, and the mucous membrane has been drawn down to it, changing a muco-cutaneous opening into one covered by mucous membrane.

The plan of treatment advised by Dr. Kelsey was to dissect this mucous membrane loose, cut it off, bring the skin up as near the verge of the anus as possible, and allow the wound to heal by granulation. A stricture of the anus would, of course, be the natural consequence, but one which Dr. Kelsey thinks should be managed and would be better than the extensive ulceration which is sure to follow the excoriation now begun.

It is needless to say that the patient's present condition is a very miserable one.

#### Alcohol Treatment of Puerperal Fever.

Dr. A. Martin delivered a lecture, on June 28, before the Berlin Society of Obstetrics and Gynecology, in which he mentioned anew the favorable influence of alcohol upon the course of puerperal fever. The administration of alcohol in puerperal sepsis was first recommended by Breisky, and eleven years later was again taken up by Runge and thoroughly discussed in several communications. Dr. Martin, whose cases were for the most part in private practice, complains that most of the cases of puerperal sepsis in private practice are brought to the physician's knowledge for the first time when the infection has already become general, and when the prospects of a local treatment are least favorable. He communicates an account of 18 of the cases in which the administration of alcohol had been possible. Five of these 18 died. The cases were of extraordinary severity, in which treatment with alcohol was begun for the first time when the fever had raged for a week and the patients had been weakened by severe complications. Thus, there existed in several cases, which finally ended in recovery, purulent parametritis, ichorous decomposition of the ovum, pyemia in one case with panophthalmitis and purulent destruction of a hip-joint; three of the cases were reckoned as of pyemia and 15 as of septicemia. Four of the 18 patients were taken sick in connection with an abortion,

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which was criminal in three cases; the other fourteen patients had given birth at the normal end of pregnancy, in three cases by artificial aid. In 4 cases local treatment was employed in addition to the use of alcohol, while in the other cases no advantage was to be expected from local treatment, except as disinfecting washes.

The alcohol was given in the form of cognac, rum, Burgundy, Bordeaux, and southern wines, for the most part mixed with champagne; the most concentrated food possible was also given. It frequently required, however, energetic persuasion on the part of the physician and of the attendants to induce the patients to take the drinks, which often had to be changed. Diarrhœa occurred at times in nearly all the patients, and when it did the drink was changed, champagne being stopped and mucilaginous drinks being given. In one of the cases, which is given in detail, the patient took within a period of six weeks the following: 17 bottles of cognac, 13 of Burgundy, 37 one-half bottles of champagne,  $4\frac{1}{2}$  bottles of other heavy wine, and 6 bottles of porter. Martin does not think, as Breisky did, that the favorable action of alcohol consists in its influence in reducing fever, but rather in a strengthening of the heart's action and in the increase of the resisting power of the individual against the ravaging action of the infection.—*Deutsche med. Wochenschrift*, July 25, 1889.

#### Treatment of Incontinence of Urine with Antipyrin.

The *Gazette Hebdomadaire*, September 27, 1889, contains an abstract of an article by MM. Perret and Devic, on the treatment of incontinence of urine with antipyrin, which was published in *La Province Médicale*, June 8 and 29, 1889. The treatment in question was tried upon some children whose nocturnal incontinence had resisted the bromides, belladonna, and hydrotherapy. During a period of seven days, at six and eight o'clock in the evening daily, two doses of seventy-five centigrammes each (nearly twelve grains) were given. The result was a diminution in the incontinence. The treatment was then suspended for eight days, but the amelioration continued. The following week the antipyrin was administered in the same doses as at first, and cure appeared to be final.

It is recommended that the remedy should

be prescribed at intervals, and continued for a long time.

#### An Epidemic of Herpes Zoster. The Etiology of the Affection.

Kaposi, in the *Wiener med. Wochenschrift*, Nos. 25 and 26, says it is generally admitted that herpes zoster is a trophic disease of the skin. It can be produced by a lesion of the invertebral ganglia. It is met with following tumors, caries of the vertebrae, and fractures, etc., which compress or destroy the ganglia. Hysterical patients are frequently subject to it. There are some cases, however, in which it is difficult to discover the cause of the lesion of the ganglia which provokes the herpes zoster, and as, on the other hand, there occur true epidemics of the affection, it may be asked if the disease is not of infectious origin. A number of reasons may be adduced in favor of the latter hypothesis. First and foremost, there are the epidemics. Kaposi in particular, in the interval between November, 1888, and February, 1889, saw more than forty cases of herpes zoster; although ordinarily the affection is very rare. Again, the epidemics occur at certain seasons of the year, particularly in the spring and autumn. Kaposi also invokes in favor of his hypothesis the observation that generally a person has herpes zoster only once. The rule is not absolute, however, since he attended one patient in his eleventh attack. Finally, it is remarkable that each epidemic has its special type. In some periods the affection is grave, in others benign. In the epidemic Kaposi observed, all the cases were remarkably benign. Only the infectious diseases, such as scarlatina, measles, typhoid fever, and variola present such temporary variations in their intensity.

If herpes zoster is infectious, how is its pathogeny to be interpreted? Kaposi thinks that there is a general infection exerting its action upon the ganglia and determining secondarily a cutaneous eruption. He admits this hypothesis because other general diseases, in particular certain intoxications, can also determine herpes zoster. Carbonic oxide, and arsenic, for example, frequently provoke this eruption. As in the case of poisoning the herpes can be explained only by a previous alteration of the nervous centres, so the same interpretation must be adopted to explain the infection of herpes zoster.—*Bulletin Médical*, September 18, 1889.

## NEWS.

—Dr. R. H. Hamill has removed to 2018 Pine street, Philadelphia.

—The American Public Health Association held its seventeenth annual meeting in Brooklyn October 22-25.

—Johnstown, Pa., was free from typhoid fever Oct. 16, and, on the authority of the Red Cross Association, may be considered fairly safe from danger for the present season.

—According to the latest advices, cholera continues to be epidemic in the Philippine Islands, although the disease is now on the decrease. The number of cases reported so far have been 22,397.

—Diphtheria is said to be prevailing to some extent in Allentown, Pa., and the ravages of the disease have been severe in some families. One man lost three children within a week and had two other children very sick.

—There has been an alarm at Yale College, in regard to typhoid fever. Exaggerated accounts led to the fear that there was danger of a epidemic; but from the latest and most reliable accounts this seems to be unlikely.

—At the semi-annual meeting of the Philadelphia Pathological Society, Oct. 24, Dr. John Guiteras delivered an address upon Some Features of Southern Pathology. After the meeting a reception was given to Dr. Guiteras at the University Club.

—The Charité Hospital in Berlin, which is so well known as the cradle of many important medical investigations and the school in which many lights of the profession have been trained, is about to be extensively enlarged and to have a new Polyclinic added.

—An epidemic of small-pox has broken out on the Austrian frontier. In Jägersdorf 329 cases have been reported and 37 deaths, and in Gotschorf, a small town with about one thousand inhabitants, 55 cases with 4 deaths. The epidemic shows no signs of abating.

—Another sporadic case of yellow fever has been reported at Key West, Florida, and in consequence quarantine restrictions have been resumed. The patient is a man, who left Havana on September 21 for New York by sea, came from New York by rail to Key West, October 2, and was taken sick October 22, in a locality of the city distant from that of the former cases.

—Among the ten true bills of indictment found by the Camden Grand Jury, Oct. 21,

was one against Dr. S. Preston Jones for maintaining a nuisance in the shape of a private insane asylum at Merchantville, N. J. Dr. Jones was formerly in charge of the Male Department of the Pennsylvania Hospital for the Insane, and his fellow-townsmen at Merchantville found themselves annoyed by the patients in his private asylum.

## OBITUARY.

## PHILIPPE RICORD.

Dr. Philippe Ricord, the celebrated teacher of venereal disease and syphilography, died in Paris, Oct. 22, 1889, at the age of eighty-nine years.

Though Dr. Ricord was accounted a French physician and was a member of the Academy of Medicine, he was born in Baltimore. He was the grandson of a distinguished physician of Marseilles and a brother of J. B. Ricord, the author of works on language, medicine, and natural history, many of which were first published in this country. Under this brother he made a number of scientific studies, and began the study of medicine in Philadelphia. In 1820 he went to Paris. He was admitted to the study of surgery—first at the Hôtel Dieu under Dupuytren, then at the Pitié under Lisfranc, receiving the degree of Doctor of Medicine in 1826. In 1828 he delivered a course of lectures on surgery in Paris and in 1831 he was appointed Surgeon-in-Chief to the Venereal Hospital of the Midi. At this hospital, from which he retired on account of age in 1860, he gained a great reputation as a syphilographer. By a decree bearing date July 28, 1862, he was appointed physician in ordinary to Prince Napoleon, and on October 26, 1869, was named consulting surgeon to Napoleon III. He became a Commander of the Legion of Honor, and in 1871 was made a Grand Officer for services during the siege of Paris. He also received many foreign decorations. He has been an active writer, several of his works on surgery having been crowned by the Academy of Sciences. For many years he was known in Paris as "the great American doctor," and he has always had a warm interest in his native land. Ricord leaves a name never to be forgotten in the history of syphilography, and, during the active years of his life, he was the most famous specialist in his line in the world.

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